SECTION 9100
LIMIT ON AMOUNT OF DISPROPORTIONATE SHARE PAYMENT TO A HOSPITAL

A hospital's disproportionate share payments during its fiscal year may not exceed the sum of the payment shortfall for MA recipient services and the unrecovered cost of uninsured patients. The amount of disproportionate share payments which exceed this limit shall be determined retrospectively after a hospital completes its fiscal year. (Statutory Background. Section 1923(g) of the federal Social Security Act.)

Payment Shortfall for MA Recipient Services. The payment shortfall for MA recipient services is the amount by which the costs of inpatient and outpatient services provided MA recipients exceed the payments made to the hospital for those services excluding disproportionate share payments under §5240 and §8250. If payments exceed costs, the financial gain from MA will not be applied against the unrecovered cost of uninsured patients.

The cost will be established by multiplying charges for inpatient and outpatient services by a ratio of costs to charges for patient care services. The ratio will be determined from the most current audited Medicaid cost report on file with the Department. Services provided MA recipients covered by an HMO under the WMAP will be included.
For outpatient MA services, interim outpatient payments limited to charges for the hospital's fiscal year will be used. For inpatient MA services, payments limited to charges will be also used. Payments limited to charges will be the lesser of (a) charges made by the hospital during its fiscal year for MA services, or (b) overall payments from all sources (as defined in §9000) for MA services during its fiscal year excluding disproportionate share payments. This charge limit will be applied separately to payments for inpatient services and payments for outpatient services for the period of the hospital's fiscal year.

Unrecovered Cost of Uninsured Patients. The unrecovered cost of uninsured patients is the amount by which the costs of inpatient and outpatient services provided to uninsured patients exceed any cash payments made by them. If payments exceed costs, the financial gain will not be applied against the MA payment shortfall. An uninsured patient is an individual who has no health insurance or source of third party payment for the services provided by the hospital.

The cost will be established by multiplying charges for inpatient and outpatient services by a ratio of costs to charges for patient care services. The ratio will be determined from the most current audited Medicaid cost report on file with the Department.
Payments made to a hospital for services provided to indigent patients by a State or a unit of local government within a State shall not be considered to be a source of third party payment. Such payments to a hospital may include payments from county general assistance programs.

Recovery of Excess Disproportionate Share Payments. If total disproportionate share payments to the hospital for services provided during its fiscal year exceed the sum of the payment shortfall for MA recipient services and the unrecovered cost of uninsured patients, then the excess disproportionate share payments will be recovered from the hospital.

Administrative Adjustments. A hospital may request an administrative adjustment under section 11900, item N, if an amount is to be recovered. The hospital or the Department may initiate an administrative adjustment under item O after completion of the outpatient final settlement for the hospital's fiscal year.

Effective Date. This limitation applies only to hospitals owned or operated by a State or by a unit of local government beginning July 1, 1994. With respect to hospitals that are not owned or operated by a State or unit of local government, this limitation applies beginning July 1, 1995 unless the federal Department of Health and Human Services exempts such hospitals or modifies the limitation for them.

For hospitals with fiscal years in progress (not beginning) on July 1, 1994 (or July 1, 1995 if applicable), the MA shortfall and the unrecovered cost of uninsured for the fiscal year will be prorated between the period before July 1 and the period on and after July 1 based on the proportion of disproportionate share payments applicable to each period.

SECTION 10000
PAYMENT FOR SERVICES PROVIDED IN HOSPITALS OUT-OF-STATE
HOSPITALS NOT HAVING BORDER-STATUS AND MINOR BORDER STATUS HOSPITALS

10100 INTRODUCTION

Minor border status hospitals and out-of-state hospitals which do not have border status will be paid according to the DRG based payment system described in this section 10000. This payment system provides a single base DRG base rate for all minor border status and non-border status hospitals. This rate is applied to the DRG weights which have been developed for use under section 5000 for in-state hospitals and major border status hospitals. The rates do not consider hospital-specific costs or characteristics as is done for in-state and major border status hospitals. However, a minor border status hospital and a non-border status hospital may request recognition of many of these costs and characteristics through the administrative adjustments described in section 10400.

For any out-of-state hospital, border status or not, certain services will not be reimbursed according to the DRG methodology if the hospital takes the necessary action to receive reimbursement under an available alternative payment. These services and their alternative payment method are described in section 7000 and include AIDS care, ventilator patient care, special unusual cases and brain injury care.

For questions and additional information, out-of-state hospitals may contact the Department at: Hospital Unit, Bureau of Health Care Financing, P.O. Box 309, Madison, Wisconsin 53701-0309; telephone (608) 267-9595.

Any pre-established standard payment amounts which are described below and the DRG weighting factors for the current state fiscal year, July 1 through June 30 may be requested from the above address.

10200 DRG BASED PAYMENT SYSTEM For Minor Border Status and Non-Border Status Hospitals

10210 Base DRG Rate

The base DRG rate for all minor border status and non-border status hospitals shall be the standard DRG group rate which is determined under section 5160 for the hospital grouping entitled "general medical and surgical hospitals not in Milwaukee County".

10211 Wage Area Adjustment Index

For minor border status hospitals, the base DRG rate will be adjusted by the applicable wage area adjustment index which is described in section 5220. Non-border status hospitals have to take action to request a wage area administrative adjustment, under §10463 if they desire such an adjustment.

10212 Capital Cost Payment

An amount shall be added to the base DRG rate for payment of hospital capital costs. The amount shall be 100% of the average capital payment per case-mix-adjusted discharge as determined according to section 5400 for hospital located in Wisconsin. The estimate shall be based on forecasted hospital-specific capital payment rates for in-state for the rate year. A minor border status hospital and a non-border status hospital may request their capital cost payment to be adjusted pursuant to an administrative adjustment under §10464.

10220 Payment for Psychiatric Stays

Payment for psychiatric stays in minor border status hospitals and non-border status hospitals shall be based on the DRG weights applied to the grouping "other general medical-surgical hospitals" (that is, GMS hospitals not having Medicare-exempt psychiatric units). These psychiatric DRG weights are discussed in section 5150. DRG weights provided to the group "all other IMD hospitals" or to the group "general medical-surgical hospitals with Medicare-exempt psychiatric units" may be allowed pursuant to an administrative adjustment request under subsection 10461 or subsection 10462.

10230 Cost Outliers

Minor border status hospitals and non-border status hospital claims may qualify for cost outlier claims under the provisions of section 5320 except for the following modifications.

The cost outlier trimpoint for all out-of-state hospital claims will be that trimpoint amount per discharge which is provided to general medical/surgical hospitals of 100 or greater beds in Wisconsin. A hospital may request a different trimpoint under the administrative adjustments of subsection 10461 and/or subsection 10466.

Outlier payments will be determined with the use of an average state-wide cost-to-charge ratio for WMAP hospital providers located in Wisconsin. The average state-wide cost-to-charge ratio will be the ratio of the total state-wide inpatient hospital costs for WMAP services to the total charges for those services. Costs and charges used will be those used to determine the hospital specific cost-to-charge ratios under section 5322 for each respective rate year.

10300 PAYMENT NOT TO EXCEED CHARGES

For out-of-state hospitals not having border-status, payment on each discharge may not exceed the hospital's charges for allowable services. This limit applies to discharges paid under the DRG based payment system and to payment for services exempt from the DRG payment system.

For minor border-status hospitals, payments are limited to charges according to the method described in section 9000. This method limits aggregate annual payments to charges, not by individual claims.

10400 ADMINISTRATIVE ADJUSTMENT ACTIONS
(For Minor Border Status Hospitals and Non-Border Status Hospitals)

10410 Introduction. Administrative adjustment actions provide hospitals with a procedure to have payments for WMAP recipient stays adjusted for many of the hospital-specific adjustments which are routinely provided to hospitals in Wisconsin and to major border status hospitals. Most of the adjustments require the hospital to submit an audited Medicare cost report or other information. The administrative adjustment provisions in section 11000 are not available to minor border status hospitals and non-border status hospitals.

10415 Reduced Payment Possible. If an administrative adjustment results in a lesser payment than would have been provided had no administrative adjustment been requested, the lesser amount will be paid by the Department. If an administrative adjustment results in an increased payment, the increase shall be paid by the Department.

10420 Request Due Date and Adjustment Effective Date. A hospital must submit a written request to the Department for an administrative adjustment. The request must be delivered within 60 days after the date of a written notice from the Department notifying the hospital of its payment rate in order for the rate to be adjusted retroactively to its original effective date. If the Department had not previously provided written notice to the hospital of the payment rate, the hospital must deliver a written request within 60 days after the date of the WMAP's remittance check to the hospital for payment of a WMAP recipient's stay. If the request is delivered after the 60 day period, then the requested adjustment may be effective on the first of the month following the month in which the request has been delivered. Delivery date is defined in §11610.

The request must specify which of the adjustments described in subsection 10461 through 10469 below are desired. Written requests are to be sent to: Hospital Unit, Bureau of Health Care Financing, P.O. Box 309, Madison, Wisconsin 53701-0309.

10440 Effective Period. Administrative adjustments provided by the Department to any out-of-state hospital shall be effective for the rate year for which the adjustment is approved effective. A rate year encompasses the twelve month period July 1 through June 30. The adjustment shall not apply for payment of WMAP recipient discharges in previous or subsequent rate years. (See example on next page.)

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Effective Period. For example, a hospital requested a capital payment adjustment under §10464 for a recipient's discharge which occurred on January 23, 1996. The hospital discharges two more WMAP recipients on May 22 and June 3 respectively. The Department will apply the capital payment adjustment to payment of these later discharges. In this example, however, a new rate year will begin on July 1, 1996 and the hospital's capital payment adjustment will lapse. The hospital will need to again request the administrative adjustment for WMAP recipient discharges occurring in the new rate year.

10460 CRITERIA FOR ADMINISTRATIVE ADJUSTMENTS

For Minor Border Status and Non-border Status Hospitals

10461 Adjustment for being a hospital institution for mental disease (IMD).

A hospital may request an administrative adjustment to its payment if (1) it is a certified hospital for a state's Title XIX program and (2) is designated as an institution for mental disease (IMD) by the certifying state or by the federal Department of Health and Human Services. The hospital must demonstrate fulfillment of these requirements to the satisfaction of the Department for approval of its request for an adjustment to recognize its IMD status.

Three adjustments may be provided. *First*, the standard DRG group rate, which is provided in section 5160 for "hospital IMDs not in Milwaukee County", may be used as the hospital's base DRG rate in place of the base DRG rate provided in subsection 10210 above. *Second*, the DRG weighting factors provided for the hospital grouping entitled "all other IMD hospitals", pursuant to section 5150, shall be applied to psychiatric stays. *Third*, the cost outlier trimpoints which is specified in subsection 5320 for hospital IMDs of 100 beds or greater shall be applied to the hospital. (A request can be submitted pursuant to subsection 10466 below for the trimpoint applicable to IMDs under 100 beds.)

10462 Alternative psychiatric DRG weight factors for hospital with Medicare-exempt psychiatric unit.

A hospital may request an administrative adjustment to its payment for psychiatric stays if (1) it is a certified hospital for a state's Title XIX program and (2) has a Medicare-exempt psychiatric unit. The hospital must demonstrate fulfillment of these requirements to the satisfaction of the Department. The adjustment will allow application of the DRG weighting factors for psychiatric stays which are provided pursuant to the hospital grouping entitled "general medical-surgical hospitals with Medicare-exempt psychiatric units" under section 5150.

10463 Adjustment for an area wage index.

Payment under the DRG-based payment system may be adjusted by an area wage index, as determined by the Department, upon request by a hospital. The hospital must provide the name of its HCFA (Health Care Financing Administration) wage area for the Medicare program. Secondly, the hospital must provide its HCFA assigned area wage index which was in effect at the beginning of the state's rate year in which the adjustment is desired to be effective. The state's rate year covers July 1 through June 30.

The Department shall calculate a wage index as follows. The hospital's HCFA wage index will be divided by the HCFA wage index for hospitals in, not reclassified to, the Madison, Wisconsin wage area. The quotient will be multiplied by the WMAP wage index for original remaining hospitals in the Madison area. The result is the wage adjustment index for the hospital. The WMAP's area wage index for Madison is listed in appendix section 27000.

The base DRG rate shall be adjusted as follows. The base DRG rate shall be reduced by that portion related to capital costs. The remaining amount will be multiplied by the wage differential factor of .7495 and that result will be multiplied by the wage adjustment index determined above for the hospital. The resulting amount plus the capital cost portion is the hospital's adjusted base DRG rate.

10464 Adjustment of capital cost payment

A hospital may request an adjustment to its capital cost payment. The hospital must submit a copy of its audited Medicare cost report for its most recent fiscal period for which an audit has been completed. The Department will calculate the hospital's capital cost ratio from information in the audited cost report. The hospital's capital cost ratio shall be total allowable capital costs divided by total allowable costs excluding capital costs and direct medical education costs.

The hospital's capital cost ratio shall be multiplied by the standard DRG group rate under section 5160 for "general medical and surgical hospitals not in Milwaukee County". The resulting product is the adjusted capital cost payment for the hospital. This adjusted amount shall be used to establish the hospital's base DRG rate in lieu of the capital cost payment provided under subsection 10212.

10465 Disproportionate share adjustment applied to payments.

A hospital may request a disproportionate share adjustment to its payment if it qualifies under the provisions of section 5240. The amount of the adjustment will be determined as is provided in section 5240. The hospital will have to submit verifiable patient day data for determination of the adjustment.

10466 Adjustment of cost outlier trimpoint for hospitals under 100 beds

If a hospital's bed capacity is under 100 beds, then the hospital may request its cost outlier trimpoint to be set at the trimpoint per discharge which is provided to hospitals located in Wisconsin under section 5320. The hospital must submit evidence to the satisfaction of the Department that its bed capacity is less than 100 beds and that the hospital is not an IMD.

10467 Facility-specific cost-to-charge ratio for use in outlier payment calculation

A hospital may request use of its facility-specific cost-to-charge ratio for use in the calculation of outlier claim payments. The hospital must submit a copy of its audited Medicare cost report for its most recent fiscal period for which an audit has been completed. The Department will calculate the hospital's overall cost-to-charges ratio from information in the audited cost report. If the hospital has no audited cost report, then the hospital must submit a copy of its most recently completed unaudited cost report. The Department has the option to not accept the unaudited cost report and to withhold any administrative adjustment action until an audited cost report is available.

10468 Correcting adjustment due to inappropriate calculation of adjustments, including clerical errors, and changes resulting from the reopening of an audited Medicare cost report.

An inappropriate calculation of an adjustment is the application of the administrative adjustment criteria to incomplete or incorrect data contained in a cost report or to other data used by the Department to determine an administrative adjustment. Data or information supplied by the hospital to support a correcting adjustment must be auditable and to the satisfaction of the Department.

If the hospital's request for a correcting adjustment is the result of a reopened Medicare cost report, the Department shall allow the correcting adjustment if the request is received by the Department within five (5) years from the end of the reopened cost reporting period and if the dollar effect of the correcting adjustment on WMAP payments to the out-of-state hospital is $5,000 or greater.

10469 Per Diem Rate for Out-of-State Rehabilitation Hospitals

A minor border status hospital or a non-border status hospital which qualifies as a rehabilitation hospitals may request to be exempted from DRG based payment and paid under a rate per diem. The rate per diem to be paid shall be an average of the rates being paid to other rehabilitation hospitals located in the Wisconsin at the time of the MA recipient's admission, not including rates being paid new rehabilitation hospitals during a start-up period. If a rate being paid to a rehabilitation hospital is adjusted as is called for in step 1 of §6310, the statewide average rate will not be recalculated and adjusted for the out-of-state hospital until the July 1 subsequent to the patient's admission. (Payment rates are customarily adjusted each July 1 for all hospitals.) A rehabilitation hospital is a hospital that provides intensive rehabilitative services for conditions such as stroke, brain injury, spinal cord injury, amputation, hip fractures and multiple trauma to at least 75% of its patient population.

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10600 PAYMENT FOR OUT-OF-STATE HOSPITAL SERVICES, STANDARDIZED AMOUNTS

For Rate Year July 1, 1997 Through June 30, 1998

A schedule of the current standardized payments is available from the WMAP at the following address or telephone numbers.	Hospital Unit Bureau of Health Care Financing P. O. Box 309 Madison, WI 53701-0309	Telephone (608) 267-9595 FAX Telephone (608) 264-7720 Voice/TDD 1-800-362-3002

SUBSECTION REFERENCE	TOPIC	AMOUNT
For a current listing of DRG weighting factors contact the WMAP at the above address or telephone.		
10210 Base DRG Rate	Base DRG rate including an amount for capital cost payment per discharge	Contact WMAP
10220 Psychiatric Stays	DRG weights for psychiatric stays in four mutually exclusive hospital groups	Contact WMAP
10230 Cost Outliers	Base cost outlier trimpoint per discharge	$ 31,410 per discharge
	Cost-to-charge ratio	Contact WMAP
10461 Hospital IMD	Base DRG rate for hospital IMDs not in Milwaukee County (including capital cost payment per discharge).	Contact WMAP
	DRG weighting factors for psychiatric stays for group "all other IMD hospitals, not located in Milwaukee County.	Contact WMAP
	Cost outlier trimpoints per discharge for IMDs (See 10466 for available adjustment if IMD is under 100 beds)	$ 31,633 per discharge
10462 Psychiatric DRG weights for hospital with Medicare-exempt psychiatric unit	DRG weighting factors for psychiatric stays for hospital grouping entitled "all other IMD hospitals, not located in Milwaukee county"	Contact WMAP
10463 Area wage index	WMAP wage index for original remaining hospitals in the Madison wage area	1.0789
10466 Cost outlier trimpoint for hospitals under 100 beds	For general medical/surgical hospitals under 100 beds	$ 5,235 per discharge
	For hospital IMDs under 100 beds (determined IMD per subsection 10461	$ 5,460 per discharge

SECTION 11000
ADMINISTRATIVE ADJUSTMENT ACTIONS
For Hospitals In Wisconsin and Major Border Status Hospitals

11010 Introduction. The Department provides an administrative adjustment procedure that allows individual hospitals an opportunity to receive prompt administrative review of payment rates for those special circumstances and occurrences which meet the criteria described in §11900 below. It is up to a hospital to request an administrative adjustment or the Department to initiate an administrative adjustment.

Department staff review a request for an adjustment and determine if it should be denied or approved and, if approved, the amount of adjustment. If the hospital disputes the staff determination, the administrative adjustment request can be forwarded for review to the Administrative Adjustment Committee (AAC). The AAC provides a recommendation to the Department regarding the disputed adjustment. A detailed description of the policies and procedures for processing administrative adjustments is in Appendix §28000.

A hospital may file a Chapter 227 appeal regarding the Department's final decision. The appeal would be filed in accordance with the requirements of Chapter 227, Wis. Stats..

The payment rate for a hospital covered by the DRG based payment system is a schedule of several distinct components which, when applied, result in a total payment for services provided by a hospital to MA recipients. An administrative adjustment may involve the adjusting of one or more of these components.

The per diem rate for hospitals paid under a per diem rate at §6000 may have that rate adjusted through administrative adjustment actions described §11900 below. Administrative adjustment actions are not applicable to AIDS rates at §7100 and ventilator-assistance rates at §7200.

This §11000 applies only to in-state hospitals and major border status hospitals. Administrative adjustment actions for minor border status hospitals and non-border status hospitals are described in §10400.

11100 Hospital's Submission of Request for Adjustment.

A hospital must deliver a sufficient written request to the Department for an administrative adjustment. In order to be considered sufficient, the following items must be clearly identifiable in the written request: (1) that the request applies to its inpatient rate, *(2)* the effective date of the rate for which an adjustment is being requested, and *(3)* the specific administrative adjustment, circumstances or occurrences described in §11900 for which the hospital is making its request for an adjustment. The Department may, at its discretion, pursue clarification of an incomplete request and ask the hospital to submit a sufficient request.

A hospital needs to deliver a separate administrative adjustment request for each rate year. A rate year encompasses the twelve month period July 1 through June 30.

> For example, in rate year Y1, a hospital requested and received an administrative adjustment to its capital cost reimbursement for a major building program pursuant to §11900-C. If the hospital wants the same administrative adjustment in rate year Y2, then the hospital must submit a new request when the Y2 rate year arrives. The request for rate year Y1 does not carry-over to rate year Y2. For rate year Y3, the hospital would again have to request the adjustment when it comes to rate year Y3.

Requests should be addressed to:

Hospital Unit
Bureau of Health Care Financing
1 W. Wilson Street, Room 250
P. O. Box 309
Madison, Wisconsin 53701-0309.

The FAX telephone number is (608) 266-1096 but may change without notice.

11120 Due Date of Request and Effective Date of Adjustment.

The due date of a sufficient request and the effective date of any adjustment is described under each of the administrative adjustments listed in §11900.

For most but no all administrative adjustments, the "60 day rule" described in §11600 below will apply. To summarize the 60 day rule, if a request is delivered to the Department with 60 days of a rate notice from the Department, then the adjustment can be effective retroactively. If delivered after 60 days, the adjustment may be effective prospectively.

11150 Initiation of Adjustment by Department.

The Department may initiate an administrative adjustment. The Department will notify the hospital in writing that it has initiated an administrative adjustment. The effective date of the adjustment will be established according to "the 60 day rule" described in §11600 below.

11200 Reduced Payment Possible.

If an administrative adjustment results in a lesser payment than would have been provided had no administrative adjustment been applied, the lesser amount will be paid. If an administrative adjustment results in an increased payment, the increase shall be paid.

11300 Withdrawal.

Once Department staff has calculated the adjustment requested by a hospital and notified the hospital of the results, whether an interim or final adjustment, the hospital cannot withdraw its request for the administrative adjustment. The Department cannot withdraw an administrative adjustment it initiated after it has notified the hospital according to §11150.

11500 Effective Period of an Administrative Adjustment.

The effective period of any adjustment is described under each of the administrative adjustments listed in §11900. Most but not necessarily all administrative adjustments will be effective through the end of the rate year in which the administratively adjusted payment rate is effective and will expire at the end of that rate year. A rate year encompasses the twelve month period July 1 through June 30.

> For example, a hospital was notified of its July 1, 1993 rate in a notification from the Department dated July 7, 1993. On August 16, 1993, the hospital delivered a request for an administrative adjustment to its rate. According to the 60 day rule, the Department may approve the adjustment retroactively effective to July 1, 1993. The adjustment will expire after June 30, 1994. For its new rate effective July 1, 1994, the hospital must submit a new administrative adjustment request.

The Department may modify the amount of the administrative adjustment when the criteria below calls for such a modification or when the Department finds that there was an inappropriate calculation of the payment rate and/or an adjustment to the payment rate.

11600 The 60 Day Rule.

The effective date of an administratively adjusted payment rate shall depend on when the hospital requests the adjustment or the Department initiates the adjustment. For most but not all administrative adjustments, the effective date shall be established according to the following subsections.

11610 Definition, "Delivery date".

The U.S. Postal Service postmark date will be considered delivery date of a mailed administrative adjustment request. If delivered by FAX machine, the in scripted date from the Department's FAX machine shall be considered delivery date. Delivery date under any method, other than U.S. mail or FAX, shall be the day the Department receives delivery.

Delivery Date Continued

The Department is not responsible for written requests which are lost in transit to the Department. If lost, the hospital must demonstrate to the satisfaction of the Department that a "delivery date" had been established according to the above criteria. The Department recommends that hospitals use registered return-receipt U.S. mail in order that they have documentation of the postmark date and that the Department received the request.

11620 Definition, "Final rate notification".

A final rate notification, or a final notification of the rate, is a written notice to a hospital from the Department which lists one or more changed components of the hospital's rate schedule and which includes notice that the hospital has 60 days to request an administrative adjustment.

11630 Requested by Hospital Within 60 Days After Rate Notification.

A hospital must deliver a written request for an administrative adjustment *within the 60 day period* after the date of a final rate notification from the Department in order for the requested adjustment to take effect *on the original effective date* of the rates being adjusted. (See example in §11500.) The Department's notice of the adjusted rate does not start a new 60 day period.

11640 Requested by Hospital After 60 Days From Rate Notification.

If a hospital delivers a written request to the Department for an administrative adjustment *more than 60 days* after the date of a final rate notification from the Department, then any adjusted rate which results from the administrative adjustment request shall take effect on the *first of the month following the delivery date*. The Department's notice of the adjusted rate does not start a new 60 day period.

If "the first of the month following the delivery date" is in a new rate year, the request will be denied. This means that an administrative adjustment request with a delivery date after May 31 of the rate year will be denied.

> For example, August 3, 1993 was the date of a hospital's final rate notification for its rate effective July 1, 1993. On June 3, 1994 the hospital delivered a request for an administrative adjustment to its July 1, 1993 rate. According to the above 60 day rule, the adjustment would be effective July 1, 1994 which is the first of the month following the deliver date of the request. However, the request will be denied because July 1, 1994 is the beginning of a new rate year. It should be noted that the hospital may resubmit the administrative adjustment request specifically for its new July 1, 1994 rate.

11650 Requested by Hospital Before New Rate Year Begins.

A hospital may wish to request an administrative adjustment before a new rate year begins. Such requests will only be accepted if delivered to the Department *on or after the May 1* date preceding the beginning of the new rate year. A new rate year begins every July 1. When a hospital receives its new rate notification from the Department, it should verify that the new rate includes the requested adjustment.

11660 Administrative Adjustments Initiated by the Department.

If the Department initiates the adjustment within 60 days after the date of a final rate notification, the adjustment shall take effect on the original effective date of the rates being adjusted. If the Department initiates the adjustment more than 60 days after the date of a final rate notification, the adjustment shall take effect on the first of the month following the date on which the Department initiates the adjustment. The date the Department initiates the adjustment is the date of the written notification which is provided to the hospital according to §11150. A new 60 day rule period shall be allowed the hospital commencing with the date of notification to the hospital of the adjusted rate if the Department's adjustment causes a reduction of reimbursement.

The Department may initiate an administrative adjustment when it establishes a hospital's rate for a new rate year and include the adjustment in the Department's rate notification to the hospital.

11670 Correction of Inappropriate Calculations. The Department may find an inappropriate calculation of a hospital's rate coincident with its processing a hospital's administrative adjustment, whether requested by the hospital or initiated by the Department. An inappropriate calculation of rates is defined in §11900-A. The Department's correction of the inappropriate calculation will be effective the date the administrative adjustment is effective. If a requested adjustment is denied, the correction of the inappropriate calculation found by the Department will be effective the date the requested adjustment would have been effective had it been approved. A new 60 day rule period shall be allowed the hospital commencing with the date of notification to the hospital of the corrected rate if the correction causes a reduction of reimbursement.

For example, the adjustment requested by a hospital provided a $10 rate increase. An inappropriate calculation found by the Department caused a $2 decrease. Even though the net effect is an $8 rate increase, the isolated effect of the Department's correction caused a $2 decrease. As a result, the hospital will have a new 60 day period for requesting an administrative adjustment.